DENTIST LOAN REPAYMENT PROGRAM
REQUEST FOR REIMBURSEMENT

ND Department of Health
Division of Health Facilities
SFN 53033 (8-2001)

Dept. Use Only

File Number:

Contract Number:

Telephone: 701-328-2352

Name of Dentist	
Name of Community	
I am requesting reimbursement from the Dentist Loan Repayment Program per Chapter 43-28.1 of the North Dakota Century Code. I have completed the required six (6) months of full-time service in a community and I am therefore eligible to receive the first year payment.	
Date the six (6) months of full-time service completed:	First Year Payment: $

Please send my payments to:

Address City State Zip Code

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Signature of Dentist Date